DOCUMENT RESUME

ED 208 618 EC 140 073

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TITLE Parental Reactions to an Infant with a Birth Defect: A Study of Five Families.
PUB DATE Mar 79
NOTE 21p.; Paper presented at the Biennial Meeting of the Society for Research in Child Development (San Francisco, CA, March 15, 1979).

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Case Studies; *Congenital Impairments; Emotional Adjustment; Family Problems; Infants; *Interaction; Longitudinal Studies; *Parent Attitudes; *Parent Child Relationship; Self Esteem

ABSTRACT

Five families whose first born infant experienced a birth anomaly were followed for two years through a combination of home and laboratory visits. Findings suggested that the birth of an infant with a defect was experienced by the parents as a narcissistic injury and a series of narcissistic insults that affect the parents' self esteem, interfere with the normal maneuvers to reinstitute self esteem, and potentially interfere with the parenting process. Specific reactions of the parents to the birth of their infant with a defect were found to be related to their intrapsychic dynamics, to deviations from their prebirth expectations, to aspects of the infant and of the defect, to the capacity for reciprocity in the marital relationship, and to the role of the surrounding environmental supports. The five case studies highlighted the vicissitudes of parental reactions and of the parenting process. Some of the factors enhancing and interfering with parental attachment with the infant were described, as were some of the adaptive maneuvers utilized by the parents. (Author/SB)

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PARENTAL REACTIONS TO AN INFANT WITH A BIRTH DEFECT: A STUDY OF FIVE FAMILIES

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Paper presented at the biennial meeting of the
Society for Research in Child Development
San Francisco, California
March 15, 1979

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The author wishes to express her thanks to Heidelise Als, Ph.D., T. Berry Brazelton, M.D., and other members of the Child Development Unit of the Children's Hospital Medical Center, Boston, Massachusetts, for their support of this study.

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EC 140073

This paper is concerned with the concept of narcissistic injury, or an assault on a parent's self-esteem, as a helpful way of understanding the experience of parenting an infant with a birth defect. In addition, attention is given to the research methodology as a type of clinical-educative intervention that fosters a mother's self-esteem and enhances parent-infant mutuality.

The study from which this paper is drawn was an exploratory-formulative one which combined a longitudinal case-study method with opportunities for observation of parents involved in a research project. The project, which was conducted by the Child Development Unit at Childrens' Hospital Medical Center, Boston, was on the parent-infant affective and communicational systems. Five families that were considered "at risk" because of their first-born infants' birth anomalies were followed for two years in a combination of home and laboratory visits. (Please see handout for the number and nature of contacts.) Although there was no control group for the study, awareness of developmental stages of normal parent-infant triads was used as a framework in order to evaluate parenting and infant development.

The methods for data collection included home visits by the investigator as well as observation in front of the parents of the Brazelton Neonatal Behavioral Assessment Exam, observation of face-to-face interactions between mother, father, and infant, and observation of the parents as they watched and discussed videotape playbacks of the interactions. In addition, the investigator developed a semistructured interview with which to gather clinical information about each parent's developmental level as reflected in his or her capacity for object relationship functioning and ego strengths,

expectations about becoming a parent, marital equilibrium, attitudes about the child, and manifestations of initial and ongoing reactions and adaptations to his or her infant.

The aim was to watch the adaptational process unfold and to learn from the parents how they attached to their infants, if and how the positive symbiosis occurred, and how the infant's thrusts for differentiation was experienced. In addition, the aim was to understand how the parents handled their own feelings and to learn what negotiations they used to reconstitute a sense of well-being and to develop some pleasure in their infant, so they could provide the necessary parenting. Furthermore, although this was not specifically an intervention study, the exploratory-formulative level of research enabled the investigator to be flexible, and educative/and or clinical interventions were provided by either the investigator or the team psychologist as clinically indicated.

Briefly, the families and infants are as follows: (Please see handout for identifying information.)

The S Family: Conception was unplanned but wanted and occurred three months after the marriage. Each parent wanted a daughter. Mrs. S looked forward to natural childbirth and breastfeeding. The infant was delivered by Caesarean section and was born with cleft lip and palate, hypospadius, and a heart murmur. He was discharged from the hospital after the mother, had early special feeding needs, and was difficult to organize and modulate because of breathing difficulties. He required eight surgical interventions during his first two years, most of which were cosmetic repairs of his lip. However, during one of the procedures, he went into congestive heart failure, and he later underwent open-heart surgery to correct his paten ductus. During the first procedure for his hypospadius when he was two years old, he aspirated and was resuscitated.

The C Family: Conception was planned and wanted and occurred after seven years of marriage. Mrs. C wanted a daughter and Mr. C preferred a son. Mrs. C was looking forward to natural childbirth. This infant was born by Caesarean section after a long, difficult labor. The parents initially thought they had a healthy little girl and only learned about her congenital cataracts on her second day of life. The mother was isolated from the infant for seven days because of a postdelivery infection. During this time, the father provided the caretaking. This role continued during most of the infant's first eight months, when the mother was depressed.

The infant was nervous and sensitive but could be calmed by a pacifier or by being held. She had three surgical procedures in her first eight months, and it was not until the last operation that the parents knew that they had a visually impaired rather than a blind child.

The W Family: Conception was planned, occurred after four years of marriage, and was wanted by Mrs. W, although Mr. W was ambivalent. Each preferred a daughter. Mrs. W was looking forward to a healthy pregnancy, natural childbirth, and breastfeeding. The mother was hospitalized for six weeks beginning in her sixth month of pregnancy because of toxemia, and the infant's chance of survival was considered "at risk." Labor was induced one month prematurely. The infant suffered respiratory distress, and three fingers on each hand were fused. He evidenced a highly sensitive organizational state, but this was due to his neurological immaturity rather than his digital defect. Mrs. W decided not to breastfeed her infant since she felt like such a failure due to the complications surrounding the pregnancy, premature birth and her infant's birth defect. Between ages 14 and 21 months, he underwent four surgical procedures to separate his fingers.

The B Family: Conception was unplanned but wanted by Ms. B. The couple had a four-and-a-half year relationship, but were not married. Ms. B was looking forward to natural childbirth and breastfeeding her infant. Again, a Caesarean section was performed after a long, difficult labor. The infant had a hemangioma on his lip, a lump under his neck, and wide-set ears. Although the mother was isolated from him for his first three days because of a postdelivery infection, she was able to breastfeed. He required no surgical interventions, and he was very calm and well organized with an engaging smile and vigorous suck. The mother viewed him as a "replacement child" for a friend's baby that had previously died and this explanation served to protect her self-esteem.

The A Family: Conception was unplanned, occurred after a year of marriage, and both parents felt ambivalent about the pregnancy. Financial stresses existed since Mrs. A was laid off from work just prior to the pregnancy and Mr. A was unemployed during most of the pregnancy and the infant's first year. Each parent preferred a son to carry on the family name. By the end of the pregnancy Mrs. A was looking forward to being a mother, and hoped to give natural childbirth and to breastfeed. The infant's delivery was uncomplicated, although the mother had had a kidney infection during her last trimester and was worried that the antibiotics might hurt the baby. The infant was born with an absent right ear diagnosed as congenital atresia. Mrs. A was able to breastfeed as she wished, and no surgical interventions occurred. At three months it was determined by x-ray that the child had an ear drum and 75 percent hearing in that ear. The parents decided not to submit her to surgical reconstruction of the ear canal because of the riskiness of the procedure and because she has compensated well for the 25 percent hearing loss.

The earlobe can be cosmetically corrected when she is older. This infant was very calm and well-organized and had an intense gaze and vigorous suck. In addition, Mrs. A had a sister who had had birth defects, which provided her with a model for adaptation to such situations.

The findings of this study suggested that narcissism and narcissistic injury were helpful theoretical concepts which seemed to explain partially the behavioral patterns that occurred within the families in this study, provided some clues as to their intrapsychic dynamics, and indicated some direction for clinical interventions. The theoretical framework includes the role of normal narcissism and self-esteem in pregnancy, in parenting, and in child development and implies the normal narcissistic aspirations for the infant and the ego ideal of the parents.

Although no definitive statement can be made from this small sample, it seemed that these five families made up a continuum of reactions to the birth of an infant with a defect. In the S, C, and W families, the discovery of the infant's defect was experienced as an assault to the parents' self-esteem rather than as a fulfillment of their aspirations. In the A and B families evidence of narcissistic injury also existed but was less prominent.

In the S, C, and W families in particular, a period of narcissistic disequilibrium occurred. During this period, the parent apparently viewed the infant as representing the defective or bad part of the self, which led to some devaluation of the self and of the infant, loss of self-esteem, guilt, self-blame, feelings of helplessness and worthlessness, and conscious and unconscious depression. The narcissistic injury and disequilibrium seemingly were influenced not only by the reaction to the discovery of the defect that reflected the loss of the mental image of the wished-for infant. In addition, the reaction related to the loss of the parent's aspirations and ideals;

deviations from the pre-birth expectations regarding the infant; and loss of the wished-for relationship with the infant through the birth process, postpartum infection, interferences in certain caretaking practices, and/or interferences in the early communicational or affective relationship because of the infant's defect. Thus, these real events represented a series of insults and were experienced by the parent both as a blow to his or her self-esteem and as interferences in the normally counted-on regulators of self-esteem.

The period of disequilibrium in these families continued on and off over time, in various forms and degrees of intensity. A retriggering of anxiety, depression, guilt, and self-blame usually occurred in response to changes in the infant's development or to surgical procedures, or after some resolution of one of the infant's problems and subsequent parental readiness to address an additional problem. For example, during the period of narcissistic disequilibrium Mrs. S appeared disheveled and dressed her infant in pajamas instead of street clothes; she seldom took him out, and when she did, she wrapped his face or positioned him so that his face was not in view. She found ways to modulate him when not confronted by his face. Her early nicknames for him were "the rat" and "the monster," but these eventually shifted to "little pumpkin" and "scooter" as she regained some of her self-esteem and viewed him less as a negative extension of herself.

Mrs. C, in contrast, took pride in her own and her infant's appearance during the period of disequilibrium, but because of her depression and sense of her infant as a negative extension of herself, she retreated back to her job earlier than she had anticipated. This enabled her to regain a sense of competence and self-esteem. It seemed as though she needed literally to separate from the negative symbiosis and reject her infant in order to prove

that she, too, was not defective. As she regained her self-esteem, she developed some pleasurable ways to interact with her infant, which restored some of her wishes to feel like a good mother.

Mrs. W also took pride in her own and her infant's appearance, but did not regress to withdrawal or avoidance as much as did Mrs. S and Mrs. C. In addition, unlike those two mothers, she was able to acknowledge and tolerate her sense of failure and disappointment and could ask for help. This reflected her slightly higher level of development and capacity for mature object relationship functioning but was also influenced by her infant's comparatively minor defect, which was not responsible for his highly sensitive state. Similarly, the defect did not interfere with pleasurable feeding or with eye-to-eye contact and required no surgical intervention during the child's first year.

It seemed that when the infant represented the defective or bad part of the self, the parent's capacity to provide the normal parenting functions was compromised. The mothers were oversensitive to their infant's cues and needs. They tended to feel dangerous and harmful to them, and they had difficulty developing a balance between empathy and objectivity. They were involved with their infant in what Lax (1971) refers to as a negative narcissistic symbiosis, in which the infant represents the mother's impaired self. While the negative symbiosis existed, these mothers were less able to function as the auxiliary ego and symbiotic shield for their infants. The narcissistic disequilibrium needed to shift so that each mother's energy was freed up for object investment and to enable her to develop trust in her parenting capacities.

Among Mrs. S, Mrs. C and Mrs. W, the experience of the infant as a negative extension of the self had both internal and external components. The reactions depended in large part upon the severity and conspicuousness of the infant's defect, the outcome of necessary surgical interventions, and the interferences in the early affective and communicational relationship. Within these families, those defects that made the initial communication between parent-child more difficult (such as the cleft lip and palate and the cataracts) and those that coincided with a vulnerable aspect of the mother's self-perception encroached more on the mother-infant dyad than other defects. For example, Mrs. S had felt that feeding her infant would be her one area of parental competence, yet she was denied a pleasurable feeding experience with her infant because of his cleft lip and palate. Mrs. C viewed her poor eyesight as her only flaw, and thus her infant's defect, congenital cataracts, hit directly at her own sense of defectiveness.

The mothers who experienced the most severe sense of injury and period of disequilibrium experienced a variety of let-downs in their pre-birth expectations and gave birth to infants with severe defects that interfered with early feeding, eye contact, or smiling situations. These behaviors have been found to elicit maternal responses (Robson and Moss, 1971; Bowlby, 1969). Their infants also had more uncertain medical outcomes and more surgical intrusions during the first years. The discovery of the infant's defect was less upsetting for those mothers who had an explanation for why the defect had occurred; who had some of their pre-birth expectations realized, which helped them to maintain aspects of their parental ego ideal (for example, Ms. B and Mrs. A were able to breastfeed); and who gave birth to infants with more minor defects. Although visible and on the face, neck,

and head, these defects did not interfere with the infants' provision of the necessary cues to elicit maternal responses. In addition, the A and B infants were also calm and well organized and did not initially demand dramatic parenting adjustments. Thus, the infants' temperament, characteristics, and ego development also affected the adaptational process. Although neither Mrs. A nor Ms. B had difficulty attaching to their infants, each of these mother's psychodynamics interfered with their initial responses to their infant's trusts for differentiation from the mother-infant symbiosis.

All of these mothers, however, found ways to attach to their child and learned to experience enough pleasure to provide the necessary ego functions of parenting. A process of adaptation and restoration of the narcissistic equilibrium occurred. This adaptational process was influenced by a complex interplay of aspects of the mothers, fathers, infants, marital relationship, and surrounding environmental supports and included many important adaptive maneuvers. For example, the role of mastery, to regain a sense of control, was important. The parents told friends of their problems, set up medical funds, and tried to work with their infants in particular ways. The father of the infant with congenital cataracts, for instance, wanted to become an "expert" on his infant's behavior so that he would know if there were any behavioral changes after her surgery.

Actual contact with the infants was also important. Every family found positive qualities in their infants to focus on, such as cuddliness, compelling eyes, and engaging smiles. They all concentrated on the normal aspects of their infants' development and often displaced their concerns onto more normalized aspects. For example, the father of the infant with multiple anomalies commented that his son was left-handed and worried that "the world was not made for left-handed people." Many of the families

protected their self-esteem by utilizing such defenses as comparing their infant to babies who were worse off, setting up a hierarchy of possible defects, and focusing on the competencies of other parents with similar children.

The parents set goals which they approached one at a time. For example, one couple commented that they would begin to go out once their child's upper lip was repaired. The surgical procedures generally helped in the healing and attachment process, functioning as milestones to which the parents could look ahead. The parents tried to focus on the fact that at least some aspects of their children's defects were correctable, and they related that they attempted to face one day and one defect at a time. The passage of time, of course, also aided the process. At one time or another, all the parents looked to the future to experience a sense of relief. Often, however, this action stirred up additional worries about how life would progress and how their children would feel about themselves and how other people would react to them. Mourning was part of the adaptational process in some of these families. It seemed that for effective mourning for the wished-for infant and wished-for relationship to occur, the mother needed first to have restored some self-esteem and to view the infant as a separate individual and not as a negative extension of herself.

In spite of the narcissistic disequilibrium, the infants were basically provided with good enough environments, given a combination of caretaking by the mothers and fathers. In these families, a reciprocity of tasks developed so that one parent was always able to be emotionally available to the infant. In general, the crisis and disequilibrium brought the couples closer together over time, although periods of marital disorganization did occur during the process. The one couple which did separate had long-standing marital problems, and the separation was not a result of the infant's birth defect.

The study demonstrated that the normally expected parent-child tasks and progressions occurred even though in some cases a negative symbiosis existed initially and there was a time-lag in the development of positive attachment and mutuality. For the most part infant development progressed normally, but not without some periods of disorganization in the parent-infant unit. As theory suggests, the parents' psychodynamics affected his or her responses to the infant's beginning separation and individuation.

Restoration of the narcissistic equilibrium occurred in ongoing ways and seemed to start when the mother (and father, if he was involved in the caretaking) felt that she had begun to know the infant's cues and could consistently respond to his or her needs. Restoration was evident in some of the following ways: (1) integration of the infant into the family so that each member's needs were able to be met, (2) discontinuation of the devaluation of the self or the infant, reflected in improved parental self-esteem, (3) allowance of other arenas for self-esteem regulation, such as work or time with friends, (4) ability to view the infant as a separate individual with unique needs, strengths, responses, and limitations, and not as a negative extension of self.

Adaptation in this sample was found not to preclude the parents' reality-based sadness for the child and awareness of their own ambivalence. Ongoing sadness for the infant and his or her situation is normal and expectable given this theoretical framework, as long as the sadness is not a continuation of devaluation of or a negative investment in the infant. As was evident in all of the families, there was no sense of closure to the adaptations and no final point of resolution at least through these first two years. Uncertainties regarding the outcome of surgical procedures and questions about the future consequences of the defect and of the child's reactions to

it remained. These findings suggest that clinical support needs to be provided over time to respond to the ongoing issues and negotiations of the parents' and the childs' narcissistic balance.

During the course of this study, it became clear to the investigator that the research methodology of the Child Development Unit in combination with the home visits provided a potential model for early intervention. This model combined a form of "crisis intervention" with focus on the parental affective and communicational relationship, and served to enhance the mothers' self-esteem and foster their affection for the mutuality with their infants.

Parents of first-born infants with congenital anomalies need support and empathy to regain their ego integrity and relieve some of the injury of having produced an infant with a defect. The parents' self-esteem was addressed via involvement in this research. They were engaged as collaborators in the process of getting to know their infant, which was ego-supportive rather than undermining. An effort was made to reinforce the adequacy of their ego functioning and competence in order to improve their parenting capacities. The team provided a type of emotional bridge or symbiotic web by viewing the infant and mother (or father) as a dyad. They stressed the separateness and competencies of each, however, by using the Brazelton Neonatal Behavioral Assessment Exam and discussing with the parents the videotaped parent-infant interactions.

During the home visits, each parent had an opportunity to tell his or her own history, which provided some narcissistic gratification in that he or she was considered important by the team. The parents were given the opportunity to ventilate feelings, which seemed to help them to maintain as allies other people involved with their infants. When appropriate, the

cognitive framework of narcissistic injury was provided to the family. The father of the child with congenital cataracts in particular experienced relief as he began to explore and understand the intensity of his own pain, feeling of defectiveness and sense that his infant exposed his defectiveness to the world. At other times, marital therapy and/or discussions about parent-child interactions and child development were initiated, particularly as the children began to separate and differentiate from the parent-child symbiosis.

Since time was an important part of the attachment process, some periods of parent-infant disorganization were observed without intervention so that the parents could find ways to develop mastery themselves and to learn about their infants in the process. The research team seemed to develop a sequence for the types of interventions when they did occur, however. First, they focused on helping each parent learn about his or her infant. This provided aid in the parent's actually experiencing the infant as separate and not just a negative extension of themself. Then mother-infant and parent-infant interactions were discussed. The team often pointed out ways that the infant in fact needed and responded to his or her mother and ways that the infant had learned to differentiate between the parents. This often helped to diminish some of the parental competition, if it existed, since parents were helped to see that different, rather than better, interactions took place. As the observational process continued, the team at times intervened in the parent-infant interactions, while at other times they addressed specific issues of the parent, such as the sense of injury, an opportunity for grieving, the importance of allowing options for themselves, or problems within the marital relationship. Often child guidance issues, such as understanding the infant's beginning separation and individuation

limit-setting, responses to tantrums, or bedtime procedures, were discussed.

Although the infants in this study primarily had correctable birth defects, the investigator assumes that the concept of narcissistic injury is also applicable when the defect is permanent. The lifelong demands on the parents of a child with an uncorrectable defect would be different, but theory regarding the role of narcissism and self-esteem in pregnancy, in parenting, and in child development suggests that similarities in the parental reactions and adaptive maneuvers would appear.

In summary, this small sample study suggests the hypothesis that the birth of an infant with a defect may be experienced by the parents as a narcissistic injury and a series of narcissistic insults that affect the parents' self-esteem, interfere with the normal maneuvers to reinstitute self-esteem, and potentially interfere with the parenting process. During the period of narcissistic disequilibrium, the parents' capacity to provide parenting functions may be compromised if they view their infant as a negative extension of self. The adaptive task for parents is to reestablish their self-esteem and to view the infant as a separate individual with strengths as well as limitations and not as a continuation of their impaired self.

The study further suggests that the loss which is often experienced is not just that of the mental image of the wished-for infant, but that of the parental aspirations and the wished-for relationship with the infant. It seems that for effective mourning to occur, the parents need first to view the infant as separate from the negative narcissistic symbiosis. One of the clinical implications of this study is that the parents' injured narcissism and self-esteem need to be addressed first, prior to grief work. These parents may be viewed "at risk" in terms of their self-esteem.

Additional research is needed to assess further the concept of narcissistic injury as a helpful theoretical framework for understanding the parental reactions and adaptations to an infant with a defect. Such research will also aid in the development of appropriate interventions to foster the parents' self-esteem, capacity to parent, and the early affective and communicational relationship with their infant.

NUMBER AND NATURE OF CONTACTS

Subjects	Home Visits			
	0-6 months	6-12 months	12-24 months	Total
Sam	5	1	1	7
Connie	6	2	1	9
Ben	4			4
Ann	6	1	3	10
Will	6	1	3	10

Subjects	Lab Visits			
	0-6 months	6-12 months	12-24 months	Total
Sam	9	2	3	14
Connie	8	4	3	15
Ben	8	1	1	10
Ann	7	2	1	10
Will	6	2	2	10

Subjects	Hospital Visits			
	0-6 months	6-12 months	12-24 months	Total
Sam	4	2	1	7
Connie	4	2		6
Ben	2			2
Ann				
Will	2			2

Subjects	Summary of Contacts		
	Age of Infant at First Contact with Team	Age of Infant at Last Contact with Team	Total Number of Contacts with Investigator
Sam	13 days	24 months	28
Connie	12 days	24 months	30
Ben	2 days	13 months	16
Ann	21 days	24 months	20
Will	2 days	24 months	22

IDENTIFYING INFORMATION

Parent	Age	Education	Infant	Sex	Defect Type	Visible	Surgical Procedures	Activity Level	Organizational State	"Positive Qualities"
Mrs. S	26	B.A.	Sam	M	Cleft lip and palate Hypospadius Heart murmer	X	4 cosmetic procedures 2 procedures for heart 2 procedures for hypospadius (All occurred during first two years)	Active	Difficult to organize and modulate	Cuddly "Winning smile"
Mr. S	40	B.A.								
Mrs. C	29	One year business college	Connie	F	Congenital cataracts	X	3 procedures in first eight months	Nervous and Sensitive	Could calm when held or with pacifier	Cuddly to Mr. C pretty
Mr. C	34	10th grade								
Ms. B	30	M.S.	Ben	M	Hemangioma on face and lump in neck	X	Possible cosmetic surgery in future	Calm and Competent	Well-organized	Bright eyes, engaging smile
Mr. B	29	Ph.D.								
Mrs. A	21	One year junior college	Ann	F	Congenital atresia (ear)	X	Possible cosmetic surgery in future	Intense and Competent	Well-organized	Intense eyes, engaging smile
Mr. A	30	Two years college								
Mrs. W	30	B.A.	Will	M	Fused fingers on each hand (also one month premature)	X	4 procedures during months 14-21 possible cosmetic surgery in future	Temperamental and Sensitive	Difficult to organize	Bright eyes, "contagious smile"
Mr. W	34	B.S.								

REFERENCES

Als, H., Tronick, E., Palmer, S., and Brazelton, T.B. 1977. Affective Reciprocity and the Development of Autonomy: The Study of a Blind Infant. Child Development, Childrens' Hospital Medical Center, Boston. Paper presented at the biennial meeting of the Society for Research in Child Development, New Orleans, Louisiana.

Bibring, G.L. 1959. "Some Considerations of the Psychological Processes of Pregnancy." The Psychoanalytic Study of the Child, eds. Ruth Eissler, et al. New York: International Universities Press, XIV, 113-121.

Bibring, E. 1953. "The Meaning of Depression" Affective Disorders. eds. Phyllis Greenacre. New York: International Universities Press.

Brazelton, T.B. 1973. Neonatal Behavioral Assessment Scale Clinics in Developmental Medicine, No. 50. Spastics International Medical Publications, London: William Heinemann Medical Books, Ltd.

Drotar, D., Baskiewicz, B.A., Irvin, N., Kennell, J.H., and Klaus, M.H. 1975. "The Adaptation of Parents to the Birth of an Infant with a Congenital Malformation: A Hypothetical Model." Pediatrics, 56:5, 710-717.

Johns, N. 1971. "Family Reactions to the Birth of a Child with a Congenital Abnormality." The Medical Journal of Australia, 277-282.

Lax, R. 1971. "Some Aspects of the Interaction Between Mother and Impaired Child: Mother's Narcissistic Trauma." International Journal of Psychoanalysis, 53, 339-344.

Robson, K. and Moss, H. 1971. "Patterns and Determinants of Maternal Attachment," The Journal of Pediatrics, LXXVII, 916-925.

Solnit, A.J., Stark, M.H. 1961. "Mourning and the Birth of a Defective Child." Psychoanalytic Study of the Child, Eds. Ruth Eissler et al. New York: International Universities Press, XVI, 523-537.

Zetzel, E. 1970. "On the Incapacity to Bear Depression." The Capacity for Emotional Growth, Ed., E. Zetzel. New York: International Universities Press, 82-114.